

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

2137-63-008951

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)	
16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III: If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	
21. I attended the deceased from Death occurred at		22. ADDRESS	
22a. SIGNATURE (Degree or title)		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)	
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.	
26. REGISTRAR'S SIGNATURE		27. REGISTRAR'S SIGNATURE	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR  
TYPEWRITER RIBBON

VS 300  
Rev. 4/59

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Ellis Funeral Home, Inc. 2820 Stoddard St.

FEB 26 1963

24 REGISTRAR'S SIGNATURE  
Road Smith, H.O.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Julian E. Culkin*

Licensed Embalmer No.

*4198*

P. O. Address

*St Louis Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.